Hospital Logo

Hospital Name

Hospital Address

**Application for Clinical Privileges – Emergency Medicine**

|  |
| --- |
| Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff Category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Effective from \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

**Request all privileges desired by checking the applicable requested box.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Request | Not Requested |  | Granted | Not Granted |
|  |  | Assess, evaluate, diagnose, and initially treat patients of all ages who present in the ED with any symptom, illness, injury, or condition. Provide immediate recognition, evaluation, care, stabilization, and disposition in response to acute illness and injury. Privileges include the performance of history and physical examinations, the ordering and interpretation of diagnostic studies, including laboratory, diagnostic imaging, and electrocardiographic examinations, and the administration of medications normally considered part of the practice of emergency medicine.. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills. |  |  |
|  |  | Admit to the appropriate level of care |  |  |
|  |  | **Procedures: Remove those procedures not within capabilities and capacities of Hospital** |  |  |
|  |  | Diagnostic procedures including arthrocentesis, lumbar puncture, slit lamp examination, tonometry, pulse oximetry, arterial blood gas sampling and analysis; EKG, and preliminary X-ray interpretation |  |  |
|  |  | Techniques utilized to stabilize the airway including the use of airways and rapid sequence intubation, image guided and video assisted laryngoscopy and use of paralytic agents |  |  |
|  |  | Cricothyrotomy and tracheotomy |  |  |
|  |  | Mechanical ventilation - temporary |  |  |
|  |  | Skeletal procedures including stabilization of fractures and dislocations; immobilization techniques; reduction techniques; backboard and cervical immobilization techniques |  |  |
|  |  | Excision of thrombosed hemorrhoids |  |  |
|  |  | Foreign body removal |  |  |
|  |  | Gastric lavage |  |  |
|  |  | Jejunostomy and gastrostomy tube replacement |  |  |
|  |  | Wound management and closure including management of burns, nail removal, I & D abscess and evacuation of hematoma |  |  |
|  |  | Emergent delivery of newborns; Doppler fetal heart tones; pelvic exam; perimortum C-Section; and removal of IUD |  |  |
|  |  | Thoracentesis, thoracostomy, pericardiocentesis and emergent thoracotomy |  |  |
|  |  | Paracentesis and lavage |  |  |
|  |  | Suprapubic tap and catheterization |  |  |
|  |  | Vascular access including arterial catheter insertion; central venous access, venous cutdown and pulmonary artery catheter insertion |  |  |
|  |  | Use of external pacemaker and elective cardioversion |  |  |
|  |  | Administration of local anesthetics including basic and regional blocks |  |  |
|  |  | Perform and interpret emergent, focused and investigational ultrasound |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  | **Endoscopy: Diagnostic Endoscopy includes biopsy and polypectomy as applicable.** **Remove those procedures not within capabilities and capacities of Hospital** |  |  |
|  |  | Anoscopy |  |  |
|  |  | Proctoscopy |  |  |
|  |  | Sigmoidoscopy |  |  |
|  |  | Colonoscopy |  |  |
|  |  | EGD without dilation |  |  |
|  |  | EGD for removal of foreign body |  |  |
|  |  | EGD for dilation of stricture |  |  |
|  |  | **Moderate Sedation:** **Remove this privilege not within capabilities and capacities of Hospital** |  |  |
|  |  | Moderate/Conscious Sedation |  |  |
|  |  | Other Privileges Desired (Not Listed Above) |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Signature of Applicant:**

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at (Insert Name of Hospital).

I also understand that by making this request I am bound by the applicable Medical Staff Bylaws and/or policies of (Insert Name of Hospital). I also attest that my professional liability insurance covers the privileges I have requested.

I understand that it is my responsibility to provide (Insert Name of Hospital) with documentation of my education, training, current experience and information regarding the number of services and procedures I have performed in order to assist the Medical Staff in the determination of competency or continued competency.

I affirm that I will obtain a consultation with a qualified medical staff member when it is in the best interest of the patient and/or when my expertise does not meet the clinical needs of the patient.

Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws and related documents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Applicant Date**

**Medical Staff/Credentials Committee Recommendations – Privileges**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s): Please check the applicable box(es)

|  |  |
| --- | --- |
|  | Recommend all requested privileges |
|  | Do not recommend any of the requested privileges |
|  | Recommend privileges with the following conditions/modifications/deletions (listed below) |

|  |  |
| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
|  |  |
|  |  |
|  |  |
|  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Staff/Credentials Committee Date**

**Board of Directors Determination**

I/we have reviewed the requested clinical privileges and supporting documentation and make the following determination(s): Please check the applicable box(es).

|  |  |
| --- | --- |
|  | Approve all requested privileges |
|  | Approve none of the requested privileges |
|  | Approve the following privileges with the following conditions/modifications/deletions (listed below) |

|  |  |
| --- | --- |
| Privilege | Conditions/Modification/Deletion/Explanation |
|  |  |
|  |  |
|  |  |
|  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Board of Directors Date

Hospital Name

Form Approved By:

Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Board of Directors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date